

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06972

CERTIFICATE OF DEATH MD

06955

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb 68 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Georgetown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 9205 New Hampshire Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWIN M Scherr First Middle Last 4. DATE OF DEATH 5 25 19 67 Month Day Year		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9/6/13 9. AGE (In years last birthday) 33 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Audit Bureau 11. BIRTHPLACE (County & State, or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis G. Scherr 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Mrs. Esther Scherr, 9205 New Hampshire Ave. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Adenocarcinoma of Colon DUE TO (c) 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral lobular pneumonia 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4 , 19 67 , to 5/25 , 19 67 that (I) (we) last saw the deceased alive on 5/24 19 67 , and that death occurred at 12:30 AM , from causes and on the date stated above. 22a. SIGNATURE M. Shapiro M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/25/67 22c. PHYSICIAN'S NAME (Type) Morton Shapiro, M.D. 22d. ADDRESS 8107 Eastern Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/28/67 23c. NAME OF CEMETERY OR CREMATORY Beth Tilloh 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Levinson & Brothers Inc. Per. Ed. Brown 25a. REC'D BY REGISTRAR JUN 1 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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CLASSIFICATE OF DEATH

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06973

CERTIFICATE OF DEATH

06956

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospt.</u>		d. STREET ADDRESS <u>3640 Glen Eagle Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>EDWIN ALEXIS SCHMITT</u>		4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/83</u>
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ewald Schmitt</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Hesselbach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-32-1536</u>	
17. INFORMANT <u>Medical Records, Olney, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>May 21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>May 21</u> , 19 <u>67</u> , and that death occurred at <u>6 p.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Yates</u>		22b. DATE SIGNED <u>5/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard Yates</u>		22d. ADDRESS <u>Sandy Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

06232

CRIMINAL

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STATE OF NEW YORK	
COUNTY OF ...	
IN SENATE	
JANUARY 1, 1901	
REPORT OF THE	
COMMISSIONERS OF THE	
LAND OFFICE	
FOR THE YEAR 1900	
ALBANY:	
J. B. LIPPINCOTT & CO. PRINTERS	
1901	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		<u>02-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>Route #1 Box 30</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George (none) Schmitz</u>				4. DATE OF DEATH Month Day Year <u>May 15 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-2-1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>August Schmitz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ufer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>211-03-8322</u>		17. INFORMANT <u>Ruth Schmitz</u> Address <u>Route #1 Box 30 Deale, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8 Mediastinitis + peritonitis</u> DUE TO (b) <u>Ruptured esophagus + colon</u> DUE TO (c) <u>Carcinoma of Colon - Splenic Fl.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u> <u>16 hours</u> <u>Months?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 8, 1967</u> to <u>May 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 14, 1967</u> , and that death occurred at <u>2:42 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>W. W. Eastman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 15, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Eastman</u>				22d. ADDRESS <u>881 University Blvd E. Silver Spg. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE</u> <u>MAY 17 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06958

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6603 TUSCULUM ROAD		d. STREET ADDRESS 6603 TUSCULUM ROAD	
3. NAME OF DECEASED (Type or print) Herman First none Middle SCNEIDER Last		4. DATE OF DEATH May Month 2 Day 19 Year 67	
5. SEX male	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 10, 1884 82 Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEMIST-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CONNECTICUT		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT DAUGHTER Address MRS. DORIS A. SOGHOR SEE #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2040 DUE TO Chronic lymphatic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 years (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary heart failure			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 67 , to May 2 , 19 67 , that (I) (we) last saw the deceased alive on April 28 , 19 67 , and that death occurred at 9:11 M, from causes and on the date stated above.			
22a. SIGNATURE Jay R. Shapiro		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) JAY R. SHAPIRO MD		22d. ADDRESS 8218 WISCONSIN AVE. BETH., MD.	
23a. BURIAL, CREMATION, BURIAL (Specify)	23b. DATE THEREOF 5-4-67	23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEMETERY	23d. LOCATION (City or Town) (County) (State) LOS ANGELES, CALIF.
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS WASH., D.C.		25a. REC'D BY REGISTRAR MAY 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

CERTIFICATE OF DEATH

1912

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX AND COLOR

EDUCATION

DATE OF BIRTH

SEX

U.S.A.

DATE OF DEATH

PLACE OF DEATH

EDUCATION

EDUCATION

DATE OF BIRTH

DATE OF BIRTH

NAME OF DECEASED

RESIDENCE

CAUSE OF DEATH

AGE AT DEATH

SEX AND COLOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06976

CERTIFICATE OF DEATH

06959

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium + Hospital</u>				d. STREET ADDRESS <u>2920 Cortland Place N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Caroline</u> Last <u>Schneider</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-88</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph L. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Sophie M. E. Koib</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>N.W. D.C.</u> <u>MR. FERD. SCHNIEDORF 2920 Cortland Place</u>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, cerebral</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/18/67</u> , 19 <u>67</u> to <u>5/19/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/19/67</u> , 19 <u>67</u> , and that death occurred at <u>5:20 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A.W. Smith</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. A.W. Smith</u>				22d. ADDRESS <u>13018-Ga. Ave Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawlor's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W., Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAY 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

00376

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL BUREAU OF INVESTIGATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06977

CERTIFICATE OF DEATH

06960

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>3422 30th St.</u> b. COUNTY <u>Washington DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>				c. LENGTH OF STAY IN 1b <u>admitted 10/17/65</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>3422 30th St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Schufeldt, Belle, C Schofield</u>				4. DATE OF DEATH <u>May 3 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3 1881</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Wm. Thomas Craycraft</u>				14. MOTHER'S MAIDEN NAME <u>Wynne Hare</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son</u> <u>William C. Schofield</u> <u>760 Azalea Dr. Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO <u>10 yrs</u> (c)				INTERVAL BETWEEN DEATH AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>4/25/1967</u> to <u>5/3/1967</u> , that (1) (we) last saw the deceased alive on <u>3/3/1967</u> , and that death occurred at <u>2:30 p.m.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Macdon</u> M.D.				22b. DATE SIGNED <u>5/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. MACON</u>	
22d. ADDRESS <u>809 Viers Mill Rd. Rockville Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF EARNINGS

1963

For the year ending 12/31/63, the following information is furnished for the individual named below. This information is based on the records of the Social Security Administration and is subject to change without notice.

Name: *John Doe*
Social Security Number: *123-45-6789*
Date of Birth: *01/01/1925*
Place of Birth: *New York, N.Y.*
Current Address: *123 Main St., New York, N.Y. 10001*
Employer: *ABC Company, Inc.*
Occupation: *Manager*
Gross Earnings: *\$12,345.67*
Less: *1,234.56*
Net Earnings: *\$11,111.11*

John Doe
123 Main St., New York, N.Y. 10001
123-45-6789
01/01/1925
New York, N.Y.
ABC Company, Inc.
Manager
\$12,345.67
1,234.56
\$11,111.11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&21 Film 390

5/27/67 7-11-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06978

06961

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>2125 Humbarton N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5300 Westbard Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Anne Schott</u>		4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>19 67</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7- 65</u>
9. AGE (In years lost birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Schott</u>		14. MOTHER'S MAIDEN NAME <u>Diane Dempsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute interstitial viral pneumonitis</u> 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to</u> (c) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-31-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u># 3 Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Francestown, N. Hamp.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>5/27/1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06973

CERTIFICATE OF DEATH

06962

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 48 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 520 South Courthouse Road	
3. NAME OF DECEASED (Type or print) First Eric Middle Rhinehart Last SCHUELER III		4. DATE OF DEATH Month May Day 22 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1939
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eric Rhinehart Schueler, Jr.		14. MOTHER'S MAIDEN NAME Jacqueline Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1963-65		16. SOCIAL SECURITY NO.	
17. INFORMANT Road, Arlington Va.		Mrs. Gloria J. Schueler, 520 South Courthouse	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Granulocytic leukemia, acute relapse 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (H) (this hospital) attended the deceased from April 2 , 1967, to May 22 , 1967, that (H) (we) last saw the deceased alive on May 22 , 1967, and that death occurred at 1035AM , from causes and on the date stated above.			
22a. SIGNATURE R. J. Kinney		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Wisconsin Memorial Cemetery Brookfield Wisconsin	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Ives Funeral Home, 2847 Wilson Blvd. Arlington Virginia		25a. REC'D BY REGISTRAR MAY 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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OFFICE OF THE

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(Name)

John H. Smith

John H. Smith

CHIEF

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Chicago, Illinois

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06980

CERTIFICATE OF DEATH

05963

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ALEXANDRIA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL				d. STREET ADDRESS 808 TIMBER BRANCH PARKWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN DAVID SEARLE				4. DATE OF DEATH Month Day Year MAY 21 19 67			
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 JUNE 1963	
9. AGE (In years lost birthday) 3 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) HONOLULU, HAWAII	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME WILLARD SEARLE JR.			
14. MOTHER'S MAIDEN NAME NORMA JEAN WILSON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT 808 Address TIMBER BRANCH WILLARD SEARLE JR. PKWY ALEXANDRIA, VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO Acute leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from 20 MAY , 19 67 , to 21 MAY , 19 67 , that (s) (we) last saw the deceased alive on 21 MAY , 19 67 , and that death occurred at 12:55 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Jerry J. Tomasovic</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 22 May 1967	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR EVERLY WHEATLEY FUNERAL HOME 1500 W. BRADDOCK				25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	
ALEXANDRIA, VA.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DEPARTMENT OF STATE
WASHINGTON, D.C. 20520
JAN 10 1961

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06981

06964

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> 151			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <u>3311 - Glenmont Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Segal</u> Last <u></u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-91</u>	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>groceryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>		11. BIRTHPLACE (State or foreign country) <u>Crimex, Russia U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Segal</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Robt. Segal</u> address <u>503 W. Manfield Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Cardio Vascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> <u>10 hrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <u>John G. Bull</u> M.D. EXAMINER'S NAME (Type)				22. DATE SIGNED <u>5/2/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>5-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM.</u>	
23d. LOCATION (City or Town) <u>OXON HILL - MD</u>				23e. REC'D BY REGISTRAR <u>MAY 8 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASH. D.C.</u>				25. ADDRESS <u></u>			

10000

10000

Cerebral Thrombosis
Cerebral Arteriosclerosis
Cerebral Vascular Disease

John D. Buck

x 3/2/17

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06982

CERTIFICATE OF DEATH

06965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY in 1b <u>13 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2344 Bellevue Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Elmer</u> Last <u>Shea</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-93</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bookbinder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Shea</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Morris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR</u> <u>10 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>DIABETES MELLITUS</u> <u>HYPERCHOLESTEROL</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-24</u> , 19 <u>67</u> , to <u>5-7</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-7-67</u> 19 <u>67</u> and that death occurred at <u>750PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John L Ford</u>				22b. DATE SIGNED <u>5-7-67</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN LOUIS FORD</u>	
22d. ADDRESS <u>831 UNIVERSITY BLVD E. SILVER SPRING, MD</u>		22e. REC'D BY REGISTRAR DATE <u>MAY 10 1967</u>					
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					
23b. DATE THEREOF <u>5/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md</u>			
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St Washington, D.C.</u>							

S820C

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 2

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06983

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06966

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3800 Porter St - NW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				49-3			
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>D.</u> Last <u>SHEMWELL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>81</u>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. T. Dey</u>				14. MOTHER'S MAIDEN NAME <u>Sally C. Borum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-12-3099</u>		17. INFORMANT <u>Daughter - Mrs. Lash, New London, N.Y.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, severe</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture pelvis, uremia due to arterial and arteriolonephrosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall when walking along street causing fracture of Pelvis</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4/18</u> 19 <u>67</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
				20f. (City or town) <u>Washington</u> (County) <u>DC</u> (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				22. DATE SIGNED <u>May 11, 1967</u>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>May 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Ft. Geo. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Inc</u> ADDRESS <u>3072 - M St. N.W. Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 15 1967</u>		25b. REGISTRAR'S SIGNATURE	

100-100000

100-100000

[Faint, mostly illegible handwritten notes and signatures, possibly including names like "Shirley D. Charnock" and dates like "6-13-1978"]

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06967

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 426 Ridge Rd., #8	
3. NAME OF DECEASED (Type or print) First David Middle William Last Silverstein		4. DATE OF DEATH Month May Day 1 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/66
9. AGE (In years lost birthday) yrs. 8 Months 26 Days Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Palo Alto, Calif.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Silverstein		14. MOTHER'S MAIDEN NAME Martha Wachtel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Father, Morris Silverstein		Address 426 Ridge Rd. Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital polycystic kidneys with DUE TO 757.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) renal hypoplasia DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE BELDEN R. REAP M.D.		22. DATE SIGNED May 1, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		Address (Street, city, town, or county) 	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Crescent Burial Park	23d. LOCATION (City or Town) (County) (State) Camden County, New Jersey
24. FUNERAL DIRECTOR Hebrew Memorial Funeral Home, Wash., DC 20012		25a. REC'D BY REGISTRAR MAI 3 1967	
		25b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4825

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Received 1997-10-12

153

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06985

CERTIFICATE OF DEATH

06968

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>3 days 18 hrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>3980 LANGLEY COURT</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN A.B. Simpson</u>		4. DATE OF DEATH Month Day Year <u>MAY 6 19 67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/05</u>
9. AGE (In years / lost birthday) <u>61 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FINANCIAL ANALYST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FED. HOME LOAN BANK PENN.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KARL S. Simpson</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>2nd WAR.</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Virginia Simpson - WIFE - SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271 Congestive heart failure</u> DUE TO (b) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1967</u> to <u>May 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Joseph P. Kenrick</u>		22b. DATE SIGNED <u>5/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR JOSEPH P. KENRICK</u>		22d. ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>5-9-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md</u>	
24. FUNERAL DIRECTOR <u>Joseph Cawler's Sons, Inc.</u>		25. REC'D BY REGISTRAR <u>McLendon Judge</u>	
5130 Wisconsin Ave. N.W., Wash. DC.		DATE <u>MAY 10 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES OF AMERICA

1923

1923

FOR STATE
 HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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06986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06969									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON Silver Spring 151</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>					d. STREET ADDRESS <u>12004 CHARLES ROAD</u>				
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>T</u> Last <u>SLAMIN</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1967</u>				
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/15</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Colonial Cleaners</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William J. Lucey</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Michael Wood</u>		Address <u>12004 Charles Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330X Intracranial hemorrhage due to</u> DUE TO (b) <u>ruptured Berry aneurysm,</u> DUE TO (c) <u>right middle cerebral artery</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden R. Reap</u>			22. DATE SIGNED <u>5/20/1967</u>						
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>8434 Georgia Avenue Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL, SPECIAL		23b. DATE THEREOF <u>May 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Natick, Mass.</u>		
24. FUNERAL DIRECTOR <u>John B. Thomas & Sons, Inc.</u>			25a. REC'D BY REGISTRAR <u>MAY 25 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER 7ms

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06987

06970

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>4012 Decatur Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alton</u> Middle <u>L.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/09</u>		9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Henderson, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Jefferies Smith</u>				14. MOTHER'S MAIDEN NAME <u>Cora Pool</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>083-09-2089</u>		17. INFORMANT <u>Mrs. Rose Smith - 4012 Decatur Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Summer</u> , 1966, to <u>5/6</u> , 1967, that (I) (we) last saw the deceased alive on <u>5/6</u> , 1967, and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pallen</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. PALLER</u>				22d. ADDRESS <u>10400 CORNELL AVE, KENSINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06988

CERTIFICATE OF DEATH

06971

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital			d. STREET ADDRESS 11804 Eden Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Carl H. Middle Smith Last			4. DATE OF DEATH Month 15 , Day May , Year 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-86 29 Nov 95	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (County & State, or foreign country) Kentucky ?	
13. FATHER'S NAME GEORGE SMITH			14. MOTHER'S MAIDEN NAME FANNIE MOORE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO None		16. SOCIAL SECURITY NO. 304-05-6051		17. INFORMANT DAUGHTER Address SAME S.S., MRS. MARTHA PFELFER, 11804 Eden Rd., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) A2 CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 CHRONIC BRONCHIAL ASTHMA -> COR PULMONALE					INTERVAL BETWEEN ONSET AND DEATH MINUTES ? YEARS?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. Feb., 1966 to MAY 15, 1967 , that (I) (we) last saw the deceased alive on MAY 13, 1967 , and that death occurred at 5:55 A.M. from causes and on the date stated above.					
22a. SIGNATURE Gene U. Cohen, M.D.			22b. DATE SIGNED MAY 15, 1967		22c. ADDRESS 1106 SPRING ST. SILVER SPRING, MARYLAND.
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.		22d. ADDRESS SILVER SPRING, MARYLAND.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF May 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Ames Chapel Cemetery	
23d. LOCATION (City or Town) (County) (State) Orange County, Indiana		23e. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR C. Glen Carter, C. Glen Carter, 8434 Georgia Avenue, Warner E. Pumphrey, Inc. Silver Spring, Md.		25b. REC'D BY REGISTRAR MAY 17 1967			

MEDICAL CERTIFICATION

Cleared = coroner / Smullen MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Montgomery

Maryland

Montgomery

Silver Spring

U.O.A.

Silver Spring

11504 East Rd.

Holy Cross Hospital

12, May, 57

Smith

Carl W.

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22, May, 57

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Male

10-10-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

069889

CERTIFICATE OF DEATH

069772

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taboma Park</u>			c. LENGTH OF STAY IN 1b <u>23</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>20783</u>			d. STREET ADDRESS <u>8209 17th Ave.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Frances</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-'10</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Fay</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Sullivan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with</u> <u>metastases to liver & bone</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>April 28, 1967</u> to <u>5/20, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/19, 1967</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Boris Rabkin</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>				22d. ADDRESS <u>1019 Univ Blvd E</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial (Removal)</u>		23b. DATE THEREOF <u>5/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Boston, Mass.</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>				ADDRESS <u>Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

OFFICE OF THE DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06930

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>9015 Altan Pkwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Merriett Parker Smith</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/97</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry W. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Flora Hackett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>578-32-4348</u>		17. INFORMANT <u>Ellen Smith</u> Address <u>9015 Altan Parkway Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>glioblastoma multiforme</u> <u>1930</u> DUE TO <u>(malignant brain tumor)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>67</u> to <u>5/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6 May</u> 19 <u>67</u> , and that death occurred at <u>9:20 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>R. A. Mendelsohn</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. A. Mendelsohn</u>				22d. ADDRESS <u>1015 SPRING ST., SS., MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>May 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>North Scituate, Rhode Island</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06991

CERTIFICATE OF DEATH

06974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 4/7 to 5/10/67		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SISTERS of HOLY CROSS HOSP.		d. STREET ADDRESS 11407 CLOVERHILL DR.	
3. NAME OF DECEASED (Type or print) First LEAH , Middle BAER , Last SNYDER		4. DATE OF DEATH Month May , Day 10 , Year 1967	
5. SEX FEMALE	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/80
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 1 , Days 10 , Hours 19 , Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MASON BAER		14. MOTHER'S MAIDEN NAME FANNY KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 089-01-0307A	
17. INFORMANT BETTY JANE TUREN		Address 516 SP. RD. CLARK HILL DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism HOLX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis of left siliac vein DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) lobular pneumonia - pulmonary congestion			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 7, 1967 , to May 10, 1967 , that (I) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 3:00 PM , from causes and on the date stated above.			
22a. PHYSICIAN'S SIGNATURE Edward J. Richards, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-10-67
22c. PHYSICIAN'S NAME (Type) Edward J. Richards, M.D.		22d. ADDRESS 10110 Georgia Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 5/12/67	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREM.	23d. LOCATION (City or Town) (County) (State) COLUMAR MANOR, PRINCE GEORGES, MD.
24. FUNERAL DIRECTOR W.W. CHAMBERS, INC. SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAY 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

00000

CERTIFICATE OF DEATH

State of Maryland
County of Prince George's
City of Washington
District of Columbia

John Doe

4/1/80

Primary cause

Thrombosis of left iliac vein

Secondary cause - pulmonary embolism

John Doe, Jr.
Silver Spring, Md.

Edward J. Richards, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

06992

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06975

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>28 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>616 Pershing Dr.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 1511 d. STREET ADDRESS <u>616 Pershing Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Samuel Aubrey</u> First Middle Last <u>Spencer</u>			4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1912</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>			
13. FATHER'S NAME <u>William Warren Spencer</u>			14. MOTHER'S MAIDEN NAME <u>Myra Leahy</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>577-10-3792</u>		17. INFORMANT <u>Amelia H. Spencer</u> Address <u>616 Pershing Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe calcific aortitis;</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of the liver</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>May 1, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>May 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>			
				23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> 8434 ADDRESS <u>Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
<u>Warner E. Pamphrey, Inc.</u> <u>Silver Spring, Md.</u>							

2202

1990

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

— 22 —

1990-1991 3 14 (12)

2.

25

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

... ..

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06993 CERTIFICATE OF DEATH 06976

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4405 East West Highway		e. STREET ADDRESS 4405 East West Highway	
3. NAME OF DECEASED (Type or print) AIMEE H. SPICER		4. DATE OF DEATH Month May Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1879
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Nelson F. Hyatt		14. MOTHER'S MAIDEN NAME Aimee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-8441	
17. INFORMANT Daughter		Address Frances L. Stuart Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Weeks years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 20, 1963 to May 15, 1967 , that (I) (we) last saw the deceased alive on May 15, 1967 , and that death occurred 3:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE C. P. Ryland		22b. DATE SIGNED 5-19-67	
22c. PHYSICIAN'S NAME (Type) C. P. RYLAND		22d. ADDRESS 4400-49th St NW Washington DC 20016	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-67	
23c. NAME OF CEMETERY OR CREMATORY Pine View Cemetery		23d. LOCATION (City, town & county) (State) Glen Falls, New York	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25. REC'D BY REGISTRAR MAY 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

100-100000

STATE OF NEW YORK

100-100000

IN SENATE
January 1, 1934
REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
AND
JAIL HOUSES
FOR THE YEAR
1933
ALBANY: J.B. LIPPINCOTT COMPANY, 1934

NEW YORK
JANUARY 1, 1934
J.B. LIPPINCOTT COMPANY
ALBANY, N.Y.

100-100000
JANUARY 1, 1934
J.B. LIPPINCOTT COMPANY
ALBANY, N.Y.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

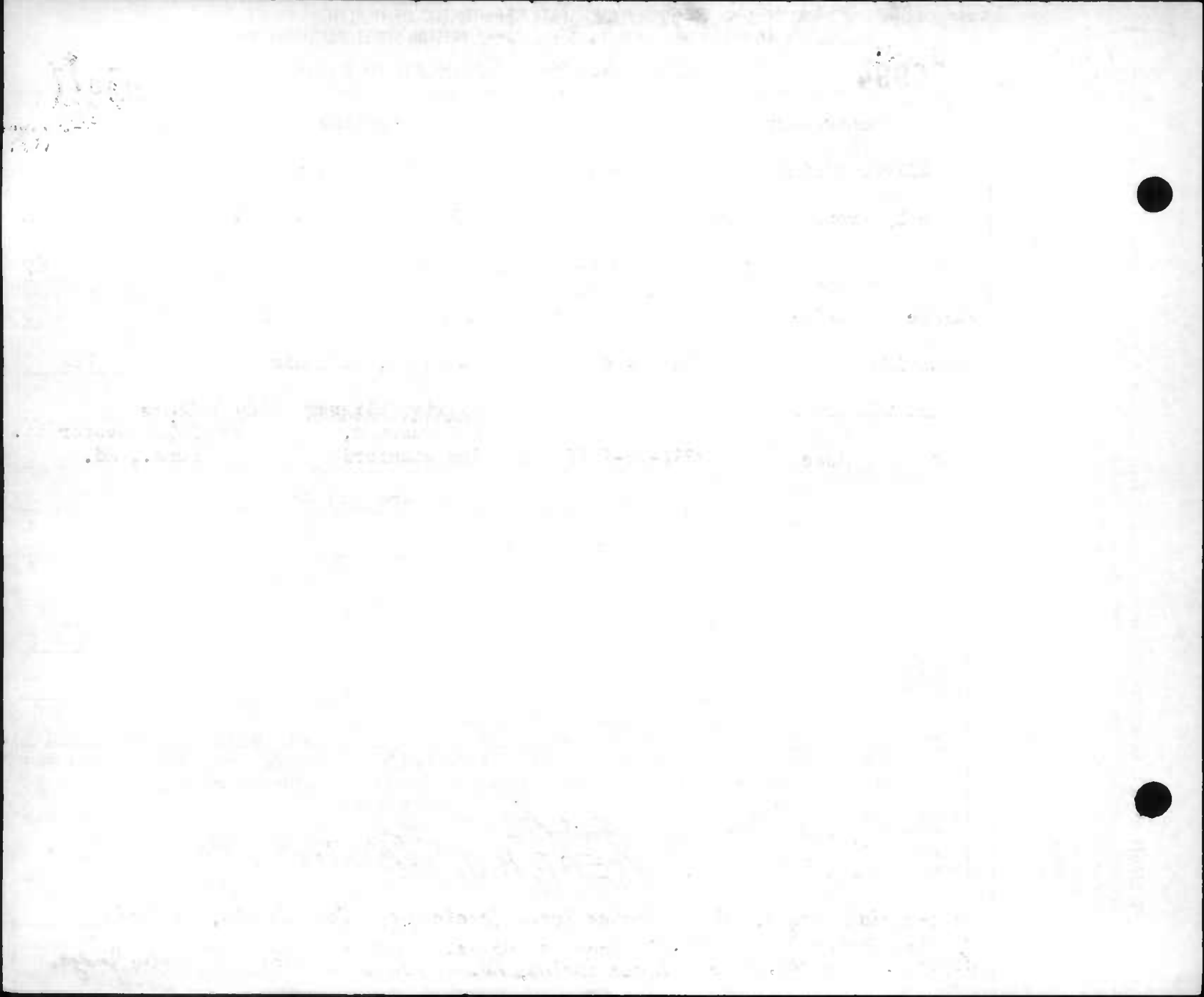
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06977

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 10714 Casper Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lois Pearl Stanford				4. DATE OF DEATH Month Day Year May 2 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/32		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Gillardon				14. MOTHER'S MAIDEN NAME Lily Hultgren Lily Hultgren			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 331-26-5455		17. INFORMANT Husband, William Stanford		Address 10714 Casper St. Kens., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO (b) Electrical shock DUE TO (c) Electrical shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Defrosting refrigerator					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5 2 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Kensington Montg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 2, 1967			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF May 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Archer Woods Cemetery		23d. LOCATION (City or Town) (County) (State) Cook County, Illinois	
24. FUNERAL DIRECTOR C. Glen Carter				ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 8 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06995

06973

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 Months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>5480 Wisconsin Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Baumann</u> Last <u>Stevenson</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-97</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Frederick Baumann</u>				14. MOTHER'S MAIDEN NAME <u>Edith Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>081-07-4573-D</u>		17. INFORMANT <u>Patricia Higier</u> Address <u>17 Magnolia Pkwy, Chevy Chase Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC Pulmonary Emphysema</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/3/67</u> , 19 <u>67</u> , to <u>5/24/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/23/67</u> 19 <u>67</u> , and that death occurred at <u>6:54</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Henry C. Services</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Services M.D.</u>				22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-39-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. MAY 29 1967 DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTRAL BANK OF INDIA

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THE CENTRAL BANK OF INDIA

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06996

06999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>15.1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4548-N. Chesapeake</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francis Sullinger</u>			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1967</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1892</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>17</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanical engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Francis Duffield Sullinger</u>				
14. MOTHER'S MAIDEN NAME <u>Jenny Collyer</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes. W.W.I.</u>				
16. SOCIAL SECURITY NO. <u>001-09-8433</u>			17. INFORMANT Address <u>Mrs. Elvera Patterson, 2540</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH 		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) (County) (State) 		21. I certify that (I) (this hospital) attended the deceased from <u>9/13, 1965</u> , to <u>present</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>5/1, 1967</u> , and that death occurred at <u>5:05 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>John B. Umhau</u>		22b. DATE SIGNED <u>5/2/67</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>			
22d. ADDRESS <u>8805 CONN. AVE. Chevy Chase, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>					
23b. DATE THEREOF <u>5/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Franklin Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Franklin Pa.</u>			
24. FUNERAL DIRECTOR <u>St. James Co 2901 14th NW DC</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06997

CERTIFICATE OF DEATH

06980

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL			c. LENGTH OF STAY in 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL, BETHESDA, MD. 20014				d. STREET ADDRESS RT2 BOX 106-107		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRIS Middle HOPE Last SULLIVAN				4. DATE OF DEATH Month MAY Day 30 Year 19 67			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 20, 1959	
9. AGE (In years last birthday) yrs. 7		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM GARRISON SULLIVAN				14. MOTHER'S MAIDEN NAME JOANN SEABER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT W. G. SULLIVAN Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X CHRONIC GLOMERULONEPHRITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 29 , 19 67 , to MAY 30 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 30 , 19 67 , and that death occurred at 5:35 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>A. E. Tompkins</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) A. E. TOMPKINS LCDR MC USN	
22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD. 20014				22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 2, 1967		23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND	
24. FUNERAL DIRECTOR MATTINGLEY FUNERAL HOME				25a. REC'D BY REGISTRAR LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06993

CERTIFICATE OF DEATH

06981

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Georgia b. COUNTY Douglas		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Douglasville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS Route 3, Box 83		
3. NAME OF DECEASED (Type or print) First William Middle Edgar Last SWOFFORD			4. DATE OF DEATH Month May Day 14 Year 19 67		
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1946		9. AGE (In years last birthday) yrs. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Gulfport, Mississippi	
13. FATHER'S NAME John C. Swofford			14. MOTHER'S MAIDEN NAME Anice Harris		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1964-1967		16. SOCIAL SECURITY NO.		17. INFORMANT Douglasville Address Georgia Mr. John C. Swofford, Route 3, Box 83	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalitis 343X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from May 12 , 19 67 , to May 14 , 19 67 , that he (we) last saw the deceased alive on May 14 , 19 67 , and that death occurred at 7:55 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>John B. Emery</i>			22b. DATE SIGNED 15 May 1967		
22c. PHYSICIAN'S NAME (Type) John B. Emery, M. D.			22d. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/1967		23c. NAME OF CEMETERY OR CREMATORY Sunset Memory Gardens	
23d. LOCATION (City or Town) (County) (State) Douglasville, Georgia					
24. FUNERAL DIRECTOR W. W. Chambers Co., 1400 Chapin St., N.W., Washington, D. C.			25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06993

CERTIFICATE OF DEATH

06982

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>13412 GLEN LEA WAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLOTTE M. TENNERY</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1967</u>			9. AGE (In years last birthday) <u>40</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Eden, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				
13. FATHER'S NAME <u>STEPHEN A. MERCER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME <u>Wilson</u> 16. SOCIAL SECURITY NO. <u>462-32-6972</u> 17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u> <u>B.J. Tennery</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>November, 1966</u> , to <u>May 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 20, 1967</u> , and that death occurred at <u>1 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ETC.</u>		22b. DATE SIGNED <u>5-22-67</u> 22d. ADDRESS <u>8641 Colesville Rd. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 24. FUNERAL DIRECTOR <u>Robert A. Pamprey F.H.</u>		23b. DATE THEREOF <u>5-22-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 23d. LOCATION (City or Town) (County) (State) <u>Sortland Rd. Prince Georges. Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK
IN SENATE
JANUARY 1, 1900
REPORT OF THE
COMMISSIONERS OF THE
DEPARTMENT OF HEALTH
FOR THE YEAR 1899

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1899.

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MEDICAL CERTIFICATION

VR A15 (4)
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DEPARTMENT OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07001

06984

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb WASHINGTON. 47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban.		d. STREET ADDRESS 5019 4th St.-N.W.	
3. NAME OF DECEASED (Type or print) First JAMES Middle THOMPSON Last THOMPSON		4. DATE OF DEATH Month MAY Day 2 Year 1967	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/1916
9. AGE (In years, last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 51 Hours 51 Min. 51	IF UNDER 24 HRS. Hours 51 Min. 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Verline C. Ager		Address 8812 Sterling	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, old and acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis, old and acute DUE TO (c) Advanced coronary arteriosclerosis DUE TO			INTERVAL BETWEEN ONSET AND DEATH Several years Years. Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John B. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/3/67	
EXAMINER'S NAME (Type)		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67	
23c. NAME OF CEMETERY OR CREMATORY Alexandria National		23d. LOCATION (City or Town) (County) (State) Alexandria, Virginia	
24. FUNERAL DIRECTOR Stewart Funeral Home		25a. REC'D BY REGISTRAR MAY 9 1967	
Address 4001 Benning Rd.,		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06985

07002

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 125 Farragut Road, Admiral Hts.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joe L THOMPSON		4. DATE OF DEATH Month May Day 9 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1918
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Ret.	
11. BIRTHPLACE (County & State, or foreign country) Clay County, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S. - yes	
13. FATHER'S NAME Joe L Thompson, Sr.		14. MOTHER'S MAIDEN NAME Jane Gilbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1939-1960		16. SOCIAL SECURITY NO. 300 10 1881	
17. INFORMANT Admiral Hts.		Address Annapolis, Md.	
Mrs. Beatrice S. Thompson, 125 Farragut Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage secondary 2043 DUE TO to thrombocytopenia, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Acute monomyelocytic leukemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Apr. 27 , 19 67 , to May 9 , 19 67 , that (b) (we) last saw the deceased alive on May 9 , 19 67 , and that death occurred at 845p M, from causes and on the date stated above.			
22a. SIGNATURE Peter T. Kirchner		22b. DATE SIGNED 11 May 1967	
22c. PHYSICIAN'S NAME (Type) Peter T. Kirchner, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR John M. Taylor Funeral Home/ Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

07003

STATE OF MARYLAND

Maryland

Montgomery

Beltsville (trial)

12 days

Arrested

Naval Hospital

122 Eastern Wood, Hospital Bldg.

Jan

THIRTEEN

May

Wife

U.S. Navy

Clark County, Kentucky

Joe L. Thompson, Jr.

John Clifford

Annapolis, Md.

Admiral Hqs.

Mr. Justice S. Thompson, 122 Eastern Wood

Joe (10-10-10)

Various past/presenting, numerous secondary
to primary points, acute
acute myocardial infarction

May 8, 1957

May 8, 1957

Peter T. Kirschner, M.D.

Naval Hospital, Bethesda, Md.

Initial

Washington National

Arlington, Va.

John M. Taylor General Home, Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07003

CERTIFICATE OF DEATH

06986

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47.3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 4200 Cathedral Ave. N.W. Apt. 714		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Brown Last TISDALE				4. DATE OF DEATH Month May Day 17 Year 19 67			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1894	
9. AGE (In years birth day) yrs. 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edmund Brown			
14. MOTHER'S MAIDEN NAME Sarah Swingley				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 572 56 8577				17. INFORMANT Cathedral Ave. N.W. Wash. D.C. VADM Mahlon S. Tisdale, USN, Ret. 4200			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.2 Pulmonary embolus DUE TO (b) Thrombophlebitis, bilateral lower extremities DUE TO (c) Peritonitis secondary to mesentric infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from May 7, 1967 , to May 17, 1967 , that (a) (we) last saw the deceased alive on May 17, 1967 , and that death occurred at 6:40 M. from causes and on the date stated above.							
22a. SIGNATURE Robert C. Cochran				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 18, 1967	
22c. PHYSICIAN'S NAME (Type) Robert C. Cochran, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Jos. Gawler & Sons				ADDRESS 5130 Wisconsin Ave., N.W., Washington, D.C.		25a. REC'D BY REGISTRAR MAY 22 1967	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20 M 1/66

07004

CERTIFICATE OF DEATH

06987

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 7 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 333 Bonifant Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Canby Last Tolson				4. DATE OF DEATH Month May Day 10 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-13-01 1891	
9. AGE (In years last birthday) 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Benjamin Can by			
14. MOTHER'S MAIDEN NAME Ida Hynson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None			
16. SOCIAL SECURITY NO. 213-40-9074-B				17. INFORMANT Christopher J. Tolson, Jr. Address 311 Bonifant Rd. Sandy Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, acute DUE TO (b) Acute sclerotic cardiac muscular disease DUE TO (c) 10 yrs							INTERVAL BETWEEN ONSET AND DEATH 10 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1958 , to May 10, 1967 , that (I) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 7:30 AM from causes and on the date stated above.							
22a. SIGNATURE Dr. A. D. Bonifant				22b. DATE SIGNED 5-10-67		22c. PHYSICIAN'S NAME (Type) Dr. A. D. Bonifant	
22d. ADDRESS Sandy Spring, Maryland				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR John B. Thomas, Inc. 8434 Georgia Avenue Silver Spring, Md.				25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

74430

UNITED STATES GOVERNMENT

74430

1. NAME OF THE PARTY		2. ADDRESS	
3. CITY		4. STATE	
5. ZIP CODE		6. PHONE NUMBER	
7. OCCUPATION		8. EDUCATION	
9. MARITAL STATUS		10. NUMBER OF CHILDREN	
11. DATE OF BIRTH		12. DATE OF DEATH	
13. PLACE OF BIRTH		14. PLACE OF DEATH	
15. RACE		16. SEX	
17. RELIGION		18. POLITICAL PARTY	
19. SOCIAL SECURITY NUMBER		20. VETERAN STATUS	
21. MILITARY SERVICE		22. AWARD NUMBER	
23. DATE OF ENTRY		24. DATE OF EXIT	
25. REASON FOR ENTRY		26. REASON FOR EXIT	
27. CURRENT STATUS		28. COMMENTS	

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07005

CERTIFICATE OF DEATH

06988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN b. <u>3 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4914 Stickley Road</u>		d. STREET ADDRESS <u>4400 Connecticut Avenue NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Effie Cleo Toole</u>		4. DATE OF DEATH Month Day Year <u>May 21 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1909</u>
9. AGE (In years last birthday) yrs. <u>58</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper Conv. Inn Motel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Craigmont Idaho</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Craigmont Idaho</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Craig</u>		14. MOTHER'S MAIDEN NAME <u>Effie May Hutchison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma to bone + Pleura</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma - primary either in intestine or kidney</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uremia terminal</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1967</u> , to <u>May 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>20 May 1967</u> , and that death occurred at <u>10⁴⁵ AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Dyer MD</u>		22b. DATE SIGNED <u>5-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Dyer MD</u>		22d. ADDRESS <u>915 19th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

25002
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 Rockville
 4414 Strickland Road
 2 ft 6 in
 Family Cemetery
 Thomas Crisp
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 (Montgomery)
 Rockville
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 2 ft 6 in
 Family Cemetery
 Thomas Crisp
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 Family Cemetery
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 (Montgomery)
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 4414 Strickland Road
 2 ft 6 in
 Family Cemetery
 Thomas Crisp
 1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07006

05989

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Union</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jane</u> (NMN) <u>Treuchtlinger</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1919</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Scalza</u>		14. MOTHER'S MAIDEN NAME <u>Mae Wilford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Not Available</u>	
17. INFORMANT <u>The Medical Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO (b) <u>Metabolic hyperkalemia</u> DUE TO (c) <u>Rheumatic Heart Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>48 hours</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>24 April</u> , 19 <u>67</u> , to <u>2 May</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2 May</u> , 19 <u>67</u> , and that death occurred at <u>1:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Juha P. Kokko</u>		22b. DATE SIGNED <u>2 May 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Juha P. Kokko, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>May 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Linden, New Jersey</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR DATE <u>MAY 5 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1433

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07007

CERTIFICATE OF DEATH

06990

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>17 1/4 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp</u>				d. STREET ADDRESS <u>3 DOMER AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY EUGENE TWING</u>				4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-95</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MASSACHUSETTS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Twing</u>				14. MOTHER'S MAIDEN NAME <u>ADA HART</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>220 34 4364</u>		17. INFORMANT <u>Chart</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 196 <u>6</u> , to <u>May 23</u> , 196 <u>7</u> , that (I) (we) last saw the deceased alive on <u>May 22</u> , 196 <u>7</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitlock</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				22d. ADDRESS <u>2217 Carroll Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cotman Manor Pk Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walter</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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[Faint, illegible text, likely bleed-through from the reverse side of the page]

Printed by the Government of India

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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07008

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY - <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>3601 Wisconsin Ave. NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Burr</u> Last <u>Upton</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25 1887</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>COLORADO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Olmstead Upton</u>				14. MOTHER'S MAIDEN NAME <u>Ellie Burr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1917-1919</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Nursing Home - chart</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u> </u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>5/16/67</u>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>May 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, P. G., Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, 5130 W. Ave., Wash. DC</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>MAY 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Charles O'Connell

Charles O'Connell

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John D. Bell

John D. Bell

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

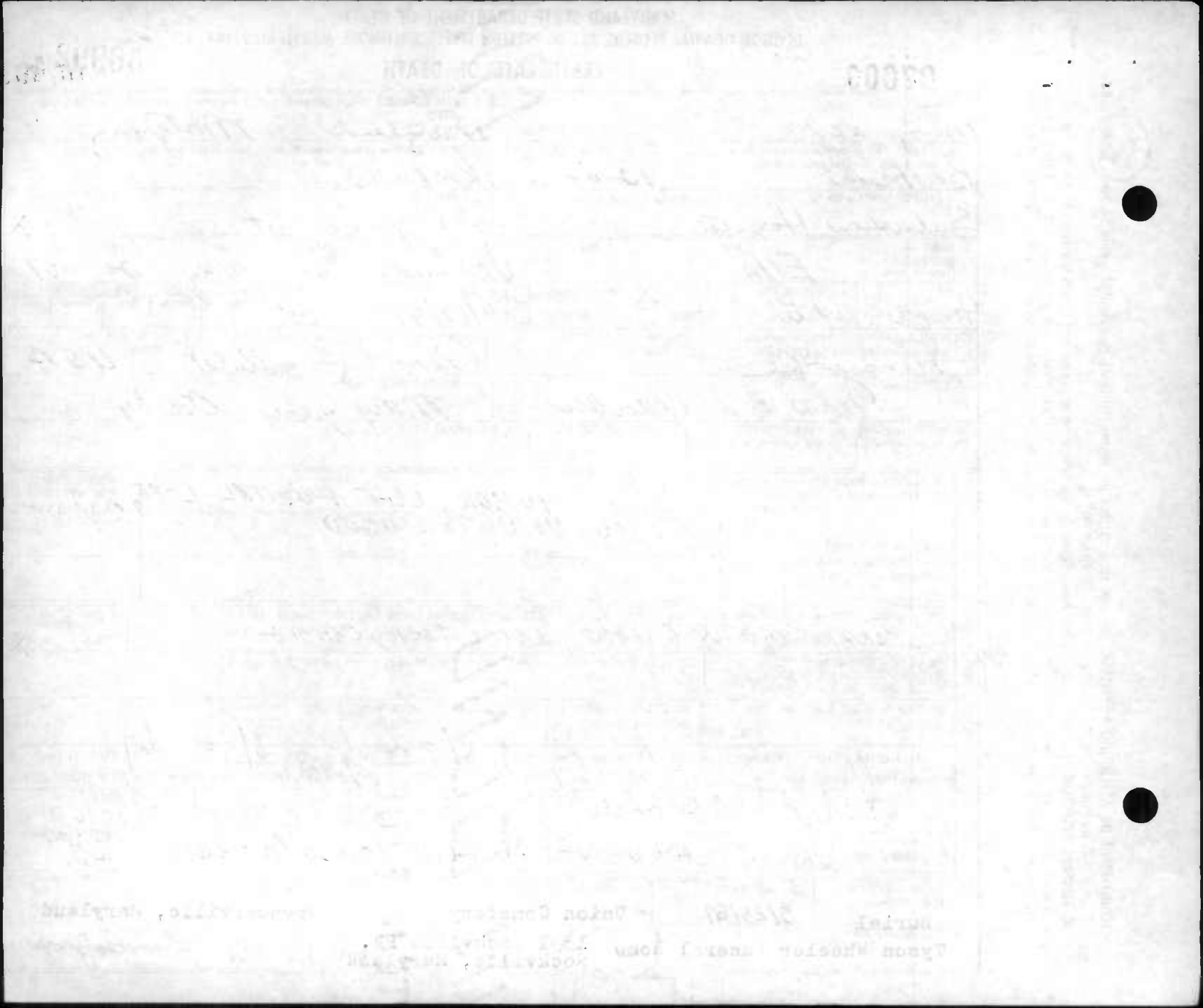
07003

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>12 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>405 Joseph St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>Van</i> Last <i>Bilder</i>		4. DATE OF DEATH Month <i>May</i> Day <i>20</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/19/98</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Glen. Fayette Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John B. Yanger</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Darby</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRAIN TUMOR, LEFT FRONTAL LOBE</i> <i>237X</i> DUE TO <i>TYPE UNDETERMINED</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CORONARY ARTERY DISEASE, NOSE TRACHEY/CARDIA</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/8</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/20</i> , 19 <i>67</i> , and that death occurred at <i>5:20 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>David Goldenberg</i>		22b. DATE SIGNED <i>5/20/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>DAVID GOLDENBERG M.D.</i>		22d. ADDRESS <i>10620 GEORGETOWN RD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/23/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Spencerville, Maryland</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>1331 Rockville Pk</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>MAY 22 1967</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06993

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 4 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital, Silver Spring, Md.		e. STREET ADDRESS 11817 Charles Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Vanish		4. DATE OF DEATH Month May Day 6 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY	
12a. BIRTHPLACE (State or foreign country) Pottsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Stephanie		14. MOTHER'S MAIDEN NAME Emma Pieron	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Peterson		Address 11817 Charles Rd Silver Spr Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Massive Rectal DUE TO (b) Hemorrhage secondary to DUE TO (c) Peptic Ulcer			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED May 7, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE OF DEATH 5-10-67	23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cemetery	23d. LOCATION (City or Town) (County) (State) Wynndmoor Pa.
24. FUNERAL DIRECTOR Robert A Pumphrey		25a. REC'D BY REGISTRAR MAY 11 1967	
25b. REGISTRAR'S SIGNATURE Robert A Pumphrey		25c. REGISTRAR'S SIGNATURE Robert A Pumphrey	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07011

CERTIFICATE OF DEATH

06994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u>	
c. LENGTH OF STAY in 1b <u>10 days</u>		d. STREET ADDRESS <u>6800 25th. Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>(None)</u> Last <u>VEDOR</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>11</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-92</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Anthony Waichulis</u>	
14. MOTHER'S MAIDEN NAME <u>Evelyn Baluskus</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>179-28-6026</u>		17. INFORMANT Address <u>Chart at Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CVA to rt hemiplegia & coma</u> DUE TO (c) <u>Hypertensive A.S.H.D.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>11 days</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischaemic mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>67</u> to <u>5/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/10</u> , 19 <u>67</u> , and that death occurred at <u>7:55</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>HUGH IREY</u>		22b. DATE SIGNED <u>5-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGH IREY</u>		22d. ADDRESS <u>7105 Riggs Road</u> <u>Lewisdale, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Plymouth Township, Pa.</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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RECEIVED
JAN 11 1967
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MEMORANDUM

TO : DIRECTOR, FBI

FROM :

SUBJECT: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07012

CERTIFICATE OF DEATH

06995

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cuyahoga</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u> 72-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u> 20014				d. STREET ADDRESS <u>8217 Bellevue Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Avonell</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 September 1922</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert Deyarmin</u>			
14. MOTHER'S MAIDEN NAME <u>Mollie Deyarmin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized sepsis secondary to high output/</u> DUE TO (b) <u>Radiation recurrent carcinoma of cervix</u> DUE TO (c) <u>8 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>17 May</u> , 19 <u>67</u> , to <u>30 May</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>30 May</u> 19 <u>67</u> , and that death occurred at <u>11:35 P.M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>E. C. Holmes M.D.</u>				22b. DATE SIGNED <u>31 May 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Elbert C. Holmes, M.D.</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 June 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Thompson Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hillsdale Indiana Pa.</u>	
24. FUNERAL DIRECTOR <u>Albert E. Rairigh</u>				25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06996

FOR STATE HEALTH DEPT

07013

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George's</u> <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's Hospital</u>		d. STREET ADDRESS <u>8340-12th Ave. N. Silver Spring, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Gregory Thomas Walker</u>		4. DATE OF DEATH <u>May 1, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/3/45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. U.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Thomas Walker Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Caplan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>George T. Walker Jr.</u>		Address <u>830 W. Washington St. Silver Spring, Md.</u>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat embolism, pulmonary</u> DUE TO <u>Fracture, left femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Automobile accident</u> (c) <u>3 1/2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Fractured left leg in auto accident causing fat emboli.</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:50 p.m. 4/27 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Hyattsville P.G. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>May 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Norfolk, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/2/52

10/2/52

Mr. [unclear] 21/12/52
 Group [unclear] 21/12/52
 Mr. [unclear] 21/12/52
 Group [unclear] 21/12/52
 Mr. [unclear] 21/12/52
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 Group [unclear] 21/12/52
 Mr. [unclear] 21/12/52
 Group [unclear] 21/12/52

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07014

CERTIFICATE OF DEATH

06997

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 3642 Glen Eagles Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Henry Middle Howard XX Last Waples				4. DATE OF DEATH Month 5 Day 27 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 12/7/89		
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Architecture		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry R. Waples				14. MOTHER'S MAIDEN NAME Kate Ada K. Gosner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-7275		17. INFORMANT Margaret D. Waples 3642 Glen Eagles Dr. Hospital Records, Olney, Md. Silver Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2925 IMMEDIATE CAUSE (a) Exsanguination DUE TO (b) Multiple Acute Gastric ulcers DUE TO (c) Chronic Refractory Anemia and Debility							INTERVAL BETWEEN ONSET AND DEATH 12 hrs 24-48 hrs years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, Pulmonary Infarction, Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/1/67 , 19 to 5/27/67 , 19, that (I) (we) last saw the deceased alive on May 27 , 19 67 , and that death occurred at 10:36 A.M. from causes and on the date stated above.								
22a. SIGNATURE Richard A. Yates				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/28/67		
22c. PHYSICIAN'S NAME (Type) Richard A. Yates				22d. ADDRESS Old Baltimore Rd., Olney, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF May 31, 1967		23c. NAME OF CEMETERY OR CREMATORY North Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Philadelphia, Penna.		
24. FUNERAL DIRECTOR Clark E. Wilson Warner E. Pumphrey, Inc.				ADDRESS Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 2 1967		
				25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

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REPUBLIC OF CHINA

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THE PRESIDENT OF THE UNITED STATES OF AMERICA

Executive Order

Whereas the President of the United States of America is authorized by the Constitution to see that the laws are faithfully executed and that the executive branch of the Government is properly organized and operated; and

Whereas the President of the United States of America is authorized by the Constitution to see that the laws are faithfully executed and that the executive branch of the Government is properly organized and operated;

Now, therefore, I, the President of the United States of America, do hereby order that the laws of the United States of America be faithfully executed and that the executive branch of the Government be properly organized and operated.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06998

07015

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>33 years</u>		d. STREET ADDRESS <u>909-Northwest Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Adelphi Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Colin L.</u> Middle <u>WARD</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mervin Ward</u>		14. MOTHER'S MAIDEN NAME <u>Helena Milligan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-2313</u>	
17. INFORMANT <u>Mervin C. Ward</u>		Address <u>Mitchellville, Md. Son-15401-Mt. Oak Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary arterioscl. heart disease</u> DUE TO (c) <u>6 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> to <u>5/26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/12</u> , 19 <u>67</u> , and that death occurred at <u>4P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard J. Walsh</u>		22b. DATE SIGNED <u>5/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Bernard J. Walsh</u>		22d. ADDRESS <u>1800 Eye St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-31-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash. D.C.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 31 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Keap

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[Vertical text on the right margin, possibly a date or reference number.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07016

06999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY in 1b <u>7 months</u>		d. STREET ADDRESS <u>16 William St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Porter</u> Middle <u>G</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Ignatius Bill Ward</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Garrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-40-9408</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u> <u>25 YEARS</u> <u>20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RENAL FAILURE - AZOTEMIA - CORONARY INSUFFICIENCY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY, 1960</u> to <u>MAY 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 2, 1967</u> , and that death occurred at <u>7:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberg</u>		22b. DATE SIGNED <u>May 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u>		22d. ADDRESS <u>310 West North Rocky Ave. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAI 8 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1150

2. 2/24/94

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07017

CERTIFICATE OF DEATH

07000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Durham</u>		d. STREET ADDRESS <u>4013 Franklin St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>McKeever</u> Last <u>Warthen</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1894</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - Lonsdale</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert + Mc Keever</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ann Orr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband William Warthen</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus with metastases</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 16, 1967</u> , to <u>May 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 13, 1967</u> , and that death occurred at <u>9:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>H.P. Dorman</u>		22b. DATE SIGNED <u>May 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.P. DORMAN</u>		22d. ADDRESS <u>5401 W. Cedar Lane Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-15-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

UNITED STATES OF AMERICA

1907

RECEIVED

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

07001

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 01-10-2001 BY 60322 UCBAW/DAW/STW

100-370

STATE OF TEXAS

2018

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

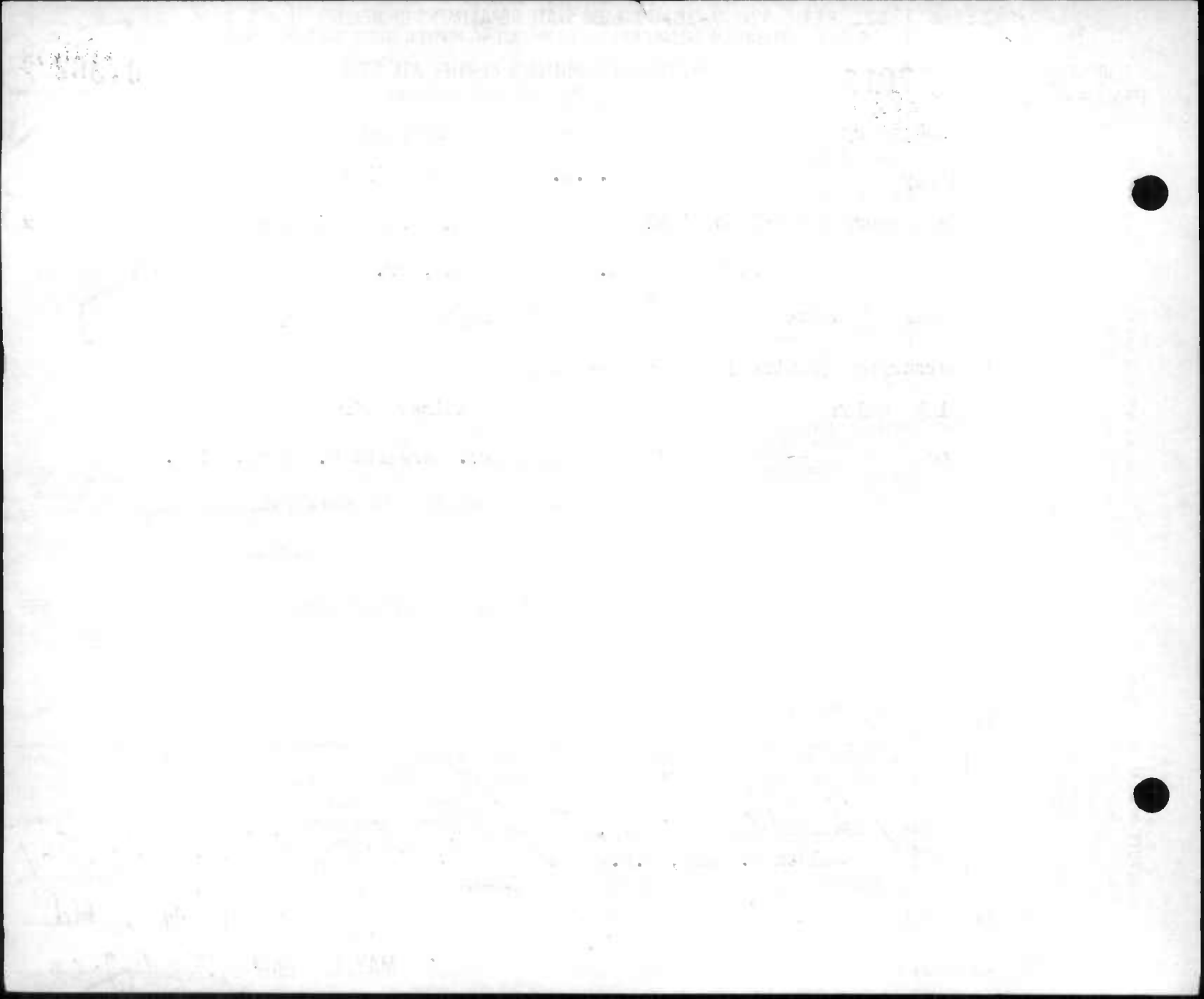
VR A15ME (5)
6M 1/66

07013

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07002

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 16 Norwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank J. Welsh, Sr.				4. DATE OF DEATH Month Day Year May 17 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/8/94	
9. AGE (In years lost birthday) yrs 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman (retired)		10b. KIND OF BUSINESS OR INDUSTRY LANDSCAPING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Nick Welsh			
14. MOTHER'S MAIDEN NAME Daisey Muir				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --			
16. SOCIAL SECURITY NO. 215-34-5360		17. INFORMANT Address Mrs. Margaret C. Welsh, Wife.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm with DUE TO 451x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) exsanguination DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Sykesville, Md.		22. DATE SIGNED May 17, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-19-67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md.	
24. FUNERAL DIRECTOR Harry W. Knight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE MAY 19 1967	
				25b. REGISTRAR'S SIGNATURE John Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07020

CERTIFICATE OF DEATH

07003

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 hrs. 25 min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>102 Cabin John Pkwy</u>			
3. NAME OF DECEASED (Type or print) <u>TWIN</u> ^{First} <u>"B"</u> ^{Middle} <u>White</u> ^{Last}				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 28 - 1967</u>	
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Gerald Hinson</u> <u>White</u>				14. MOTHER'S MAIDEN NAME <u>Donna Gail Lutz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u> Address <u>above.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 7735 DUE TO (b) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Premature Delivery</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/28/67</u> , 19 <u>67</u> to <u>5/29/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/28/67</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Vincent O'Donnell</u>				22b. DATE SIGNED <u>5/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Suburban Hosp.</u>	
22d. ADDRESS <u>5415 W. Cedar Ln. Bethesda Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>6-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BETHESDA, MD.</u>	
24. FUNERAL DIRECTOR <u>A. MCARTER, ADMINISTRATOR -</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

2007-03-01

0505

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07021

CERTIFICATE OF DEATH

07004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>31 DAYS</u>		d. STREET ADDRESS <u>2602 RANDOLPH ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID E. WHITE</u>		4. DATE OF DEATH <u>MAY 3 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mgmt. Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>
13. FATHER'S NAME <u>ELLIOTT WHITE</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>003-14-5235</u>	
17. INFORMANT <u>FLORENCE E. WHITE (WIFE)</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF THE LIVER</u> 5-811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SECONDARY TO ETHYLISM</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>January, 1964</u> , to <u>MAY 3, 1967</u> , that (I) <u>(was)</u> lost <u>saw</u> the deceased alive on <u>MAY 2, 1967</u> , and that death occurred at <u>5:55 PM</u> , from causes <u>not</u> on the date stated above.			
22a. SIGNATURE <u>Helden R. Reap</u>		22b. DATE SIGNED <u>May 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HELDEN R. REAP, M.D.</u>		22d. ADDRESS <u>WHEATON, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

ESAC

111

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07022

CERTIFICATE OF DEATH

07005

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN + Hospital</u>		d. STREET ADDRESS <u>5706 42nd AVE</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES DAVID WHITE</u>		4. DATE OF DEATH <u>5 20 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William WHITE</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Hicks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>244-10-6763</u>	
17. INFORMANT <u>cast</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, right upper & lower lobes</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bed rest etc related to resection of left colon</u> DUE TO (c) <u>Carcinoma of Recto sigmoid colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7 days</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of prostate - 3 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 10, 1967</u> to <u>May 20, 1967</u> , that (1) (we) lost saw the deceased alive on <u>May 20, 1967</u> , and that death occurred at <u>4:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W W Eastman</u>		22b. DATE SIGNED <u>May 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. W. Eastman, M. D.</u>		22d. ADDRESS <u>831 University Blvd. E. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/23/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D BY REG. STAMP <u>MAY 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

120000

UNITED STATES OF AMERICA

120000

[Faint, mostly illegible text, possibly a letter or document, with some visible words like "Dear Sir", "Very truly yours", and "Sincerely yours"]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07023

CERTIFICATE OF DEATH

07006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>2730 Wisconsin Ave. N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>EMILIE R. WHITELAW</u>				4. DATE OF DEATH Month <u>5</u> - Day <u>31</u> - Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/1879</u>		9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Rae</u>				14. MOTHER'S MAIDEN NAME <u>Ann MacGregor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Beatrice Whitelaw</u>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X cerebral infarction</u> DUE TO (b) <u>cerebral thrombosis</u> (c) <u>cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>7d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Disseminated Pneumonia systemic infection</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Diabetes</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> _____ p.m. _____ 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/29/1967</u> to <u>5/31/1967</u> , that (I) (we) last saw the deceased alive on <u>5/30/1967</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph H. Jones</u>				22b. DATE SIGNED <u>5/31/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOMES 800 4 ST NW</u>				25a. REC'D BY REGISTRAR <u>JUN 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

30079

CERTIFICATE OF DEATH

23052

[Faint, illegible text and lines, likely a form or document, with two punch holes visible on the right side.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07024

07007

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b 8 Months		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home			d. STREET ADDRESS 5119 Fairglen Lane		
3. NAME OF DECEASED (Type or print) LEONORA A. WICKER			4. DATE OF DEATH Month MAY Day 29 Year 1967		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1881	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.			13. FATHER'S NAME Alexander MacIntosh		
14. MOTHER'S MAIDEN NAME Eugenia Hancock			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Daughter Helen Wicker Address Same as Item 2.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia; (Bryophy pneumonia) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis OUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 , to 1967 , that (I) (we) last saw the deceased alive on 28 May 1967 , and that death occurred at 2:42 AM , from causes and on the date stated above.					
22a. SIGNATURE JERE J. DAUM		22b. DATE SIGNED 5-29-67		22c. PHYSICIAN'S NAME (Type) JERE J. DAUM	
22d. ADDRESS 4977 Battery Lane Bethesda, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-31-67	23c. NAME OF CEMETERY OR CREMATORY Culdee Cemetery	23d. LOCATION (City or Town) (County) (State) Moore Count, N. C.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07025

CERTIFICATE OF DEATH

07008

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 115 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 3724 Manor Rd	
3. NAME OF DECEASED (Type or print) First Louis Middle Laval Last Williams, Jr.		4. DATE OF DEATH Month 5 Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 February 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician retired		10b. KIND OF BUSINESS OR INDUSTRY USPHS	9. AGE (In years last birthday) yrs. 78
11. BIRTHPLACE (County & State, or foreign country) Hampton, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis L. Williams Sr		14. MOTHER'S MAIDEN NAME Ella Hume Ford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army (WW II)		16. SOCIAL SECURITY NO. 578 54 6764	
17. INFORMANT Hilda K. Williams		Address Chevy Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe, generalized, arteriol sclerosis 1500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Vascular disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) NA		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NA	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11 January, 1967 to 6 May, 1967 , that (I) (we) lost the deceased alive on 6 May 1967 , and that death occurred at 3.50AM , from causes and on the date stated above.			
22a. SIGNATURE K.F. SPENCE LCDR USN		22b. DATE SIGNED 6 MAY 67	
22c. PHYSICIAN'S NAME (Type) K.F. SPENCE		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 5-10-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25. REC'D BY REGISTRAR MAY 10 1967	
ADDRESS 5130 Wisconsin Ave, WDC		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE UNIVERSITY OF CHICAGO PRESS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07026

CERTIFICATE OF DEATH

07009

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MISS</u> b. COUNTY <u>Jackson Heids</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN lb
<u>8 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | d. STREET ADDRESS
<u>752 Porter st.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Louie</u> Middle <u>BEAN</u> Last <u>Wright</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>1</u> Year <u>1967</u> | |
| 5. SEX <u>7c</u> | 6. COLOR OR RACE <u>w</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 23 1888</u> |
| 9. AGE (In years last birthday) yrs.
<u>79</u> | | 10. IF UNDER 1 YEAR
Months <u>0</u> Ooys <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>At Home.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Pontapac, MISS</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Yes.</u> | |
| 13. FATHER'S NAME
<u>Sam Bean</u> | | 14. MOTHER'S MAIDEN NAME
<u>Dora Hague</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>426-16-5162A</u> | |
| 17. INFORMANT <u>Sammie W Smith</u> Address <u>12102 Bosbey Dr. Silver Spring</u>
<u>daughter</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
<u>155X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retropneumonal Carcinoma</u>
DUE TO (c) <u>Indef.</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 mos</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Hemorrhage & ventricular disturbance</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u>
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>67</u> , to <u>5/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/1</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes on the date stated above. | | | |
| 22a. SIGNATURE
<u>Stephen N. Jones</u> | | 22b. DATE SIGNED
<u>5/2/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>STEPHEN N. JONES</u> | | 22d. ADDRESS
<u>809 VEIRS Mill Rd. Rock, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5-6-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lakewood Mem. Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Jackson MISS.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert A Pomphrey</u> | | 25. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25a. ADDRESS
<u>2557 WIS. Ave. Beth Md</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| 25c. DATE
<u>MAY 8 1967</u> | | | |

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07010

07027

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA, RURAL
c. LENGTH OF STAY IN lb
116 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U.S. NAVAL HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE VA.
b. COUNTY STAFFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
STAFFORD
d. STREET ADDRESS
BOX 372 ROUTE #1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First DARYL Middle ELAINE Last YOUNG | | 4. DATE OF DEATH
Month MAY Day 29 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
CAUCASIAN | 7. WIDOWED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 1, 1967 |
| 9. AGE (In years last birthday) yrs.
3 | | 10. IF UNDER 1 YEAR
Months 29 Days 29 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
N/A | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
QUANTICO, VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HAROLD B. YOUNG | | 14. MOTHER'S MAIDEN NAME
DARLA BLACKBURN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
HAROLD B. YOUNG | | Address BOX 372 RT#1 STAFFORD, VA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5610 Congenital Malformation of Heart.
DUE TO
(b) Rt. Incarcerated Inguinal Hernia with bowel
DUE TO
(c) obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from FEB. 2, 1967 , to MAY 29, 1967 , that (I) (we) last saw the deceased alive on MAY 29, 1967 , and that death occurred at 6 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Albert E. Tompkins</i> | | 22b. DATE SIGNED
31 May 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Albert E. Tompkins | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6-2-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Greenwood Mem. Park | | 23d. LOCATION (City or Town) (County) (State)
New Kensington, Penna. | |
| 24. FUNERAL DIRECTOR
B. A. PUMPHREY
Bethesda, Maryland. | | 25a. REC'D BY REGISTRAR
JUN 5 1967
DATE | |
| 25b. REGISTRAR'S SIGNATURE
<i>John A. Judge</i> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07028

CERTIFICATE OF DEATH

07011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | | c. LENGTH OF STAY IN 1b
13 days/12 hrs. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium Hospital | | | | d. STREET ADDRESS
7401 New Hampshire Ave. | | | |
| 3. NAME OF DECEASED (Type or print)
Herbert Clarence YOUNG | | | | 4. DATE OF DEATH
Month 5 Day 2 Year 1967 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 5, 1911 | | 9. AGE (In years last birthday)
55 yrs. | IF UNDER 1 YEAR
Months 5 Days 27 | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired)
Retired - D.C. Police | | | 10b. KIND OF BUSINESS OR INDUSTRY
Police | | 11. BIRTHPLACE (County & State, or foreign country)
D.C. (Wash. D.C.) | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Elmer YOUNG | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth x Buie | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
577-01-9557 | | 17. INFORMANT
Address Hospital Records 7600 Carroll Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma -
DUE TO Primary lung.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/18 , 19 67 , to 5/1 , 19 67 that (I) (we) last saw the deceased alive on 5/1 , 19 67 , and that death occurred at 1:35 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ernest A. Sarason M.D. | | | | | | 22b. DATE SIGNED
5/2/67 | |
| 22c. PHYSICIAN'S NAME (Type)
ERNEST A. SARASON | | | | | | 22d. ADDRESS
7006 New Hampshire Ave Tak. Park Md | |
| 23a. BURIAL (CREMATION) REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
5/5/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges, Md. |
| 24. FUNERAL DIRECTOR
Youngs Funeral Home | | | ADDRESS
1300 2nd St N.W. Washington, D.C. | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

73027

REMARKS OF DEATH

1911

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of funeral home

7. Name of cemetery

8. Name of undertaker

9. Name of executor

10. Name of administrator

11. Name of guardian

12. Name of trustee

13. Name of agent

14. Name of attorney

15. Name of witness

16. Name of clerk

17. Name of judge

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

07023

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07012

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|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE <u>Massachusetts</u> COUNTY <u>HAMPDEN</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN lb
<u>14 mins</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SPRINGFIELD</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | d. STREET ADDRESS
<u>33 YAMASKA ST.</u> | |
| 3. NAME OF DECEASED (Type or print)
<u>Mary C.V. Zack</u> | | 4. DATE OF DEATH
Month <u>8</u> , Day <u>May</u> , Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>34, Dec, 1892</u> |
| 9. AGE (In years last birthday)
<u>74</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)
<u>com. off. (Hosp.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Hospital</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James J. Crean</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary L. Willmott</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Haley Funeral Home</u> | | Address
<u>Springfield, Mass.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>
DUE TO <u>Coronary Artery Heart Disease.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
_____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>0</u> a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Belden B. Reap</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>BELOEN R. REAP M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
<u>May 8, 1967</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Trans-burial</u> | | 23b. DATE THEREOF
<u>May 11, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Calvary Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Chicopee, Mass.</u> | |
| 24. FUNERAL DIRECTOR
<u>C. Glen Carter, Ken Carter, 8434 Georgia Avenue</u> | | 25a. RECEIVED BY REGISTRAR
<u>MAY 11 1967</u> | |
| Warner E. Pumphrey, Inc. Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE
<u>James Judge</u> | |



104-101

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

MAY 13 1964